Mr Jide Akinola Daramola

Samuelson Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 27 November and 5 December 2014 and was unannounced on the 27 November.

There were no previous inspections as Samuelson Lodge was registered with the Care Quality Commission on 30 April 2013.

Samuelson Lodge is a care home that provides accommodation and support with personal care for up to three adults with mental health conditions. On the day of our visit there was only one person living at the service.

The service was run by the registered provider. A registered provider has legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We found several shortfalls and breaches to multiple regulations relating to, care and welfare, records, medicine management, safeguarding, privacy and dignity, supporting staff and maintenance of premises.

Summary of findings

Staff were not always on duty to meet the needs of the person living at the service and to keep them safe. For example when we arrived at the service there were no staff on duty and we found there were not enough staff to meet the person's needs.

One person had damaged their room and there were no plans to repair the damage. Furniture including a broken mirrored cupboard and a broken bed were a potential risk to people living at the service.

Safeguarding procedures were not always followed as we were told of incidents that were not reported to the CQC. People were not always protected from abuse. For example, we were informed of incidents that should have been reported as safeguarding, on the day of inspection.

Medicines were not stored or handled appropriately. Medicines were stored in a filing cupboard that could easily be opened. Medicine administration record charts (MARS) were not completed properly and MARS prescriptions were incorrect as they had the name of the medicine but no had dose shown.

The service was ineffective. The manager described the processes that would be followed if capacity to consent were absent including best interests decisions made after discussions with an advocate. However, steps that would need to be taken to lawfully deprive a person of their liberty were not always taken.

There were inadequate measures in place to ensure that people were supported to choose and eat a balanced diet.

The service was not managed well. People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was unsafe. People were not protected from avoidable harm. The service was not always staffed over a 24 hour period, as the provider had a contract to provide six hours of support per day.

We found shortfalls relating to safeguarding, medicine management and safety and suitability of the premises.

Inadequate

Is the service effective?

The service was ineffective. The provider described the processes that would be followed if capacity to consent were absent including best interests decisions made after discussions with an advocate. However, steps that would need to be taken to lawfully deprive a person of their liberty were not always taken.

There were inadequate measures in place to ensure that people were supported to choose and eat a balanced diet.

Inadequate

Is the service caring?

The service was not caring. People were not always treated with dignity and respect. We observed that one person was left to stay in their room with broken furniture and were left alone for prolonged periods of time despite their support plan stating they needed care at specified intervals.

Inadequate

Is the service responsive?

The service was not responsive. People were not always supported to engage in activities and individual interests were not always accommodated.

We were told that a recovery model was in place. The model was intended to support people to become more independent and potentially go on to live independently. However, the support plan and risk assessments we saw in place did not always support this.

Inadequate

Is the service well-led?

The service was not well-led. Staff were not available at the service to offer 24 hour support. There were inadequate systems in place to monitor the quality of care delivered and to obtain people's views about the care they received.

The service was not managed appropriately. People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

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Samuelson Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 November 2014 and 5 December 2014 and was unannounced and was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service which included the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make. We also contacted the local authority and the local Healthwatch to obtain their views about Samuelson Lodge.

During our inspection we observed how the provider interacted with people who used the service. We looked at how people who used the service were supported during the day of our inspection.

We looked at one care record, one staff file and other records relating to the management of the service, such as policies and procedures and gas and insurance certificates.

During and after the inspection we spoke to the community mental health team to get their view of the service as they had weekly contact with one person using the service.

Inadequate

Is the service safe?

Our findings

The service was unsafe. During our inspection, we found that people were at risk of receiving inappropriate and unsafe care because the delivery of care did not meet individual needs. At the time of inspection there was only person using the service. We looked at the care records and found that these were not reassessed properly. For example, a support plan in place from December 2013 outlined that care was to be given at specified hours. We arrived during times specified within the care plan and could hear footsteps inside but no one answered the door. However, there was no staff at the service as we called the provider who confirmed that no staff were at the premise. We had to contact the provider each time we visited to ensure we gained entry as they confirmed that the service was only staffed at night. When we contacted the manager by telephone they said staff would be available later in the day.

The provider said they supported one person with shopping every week. However, whether meals were purchased or not or whether a person ate a balanced meal daily was not always recorded as outlined in the support plan. On 27 November 2014 the fridge was empty. The provider told us the person would beg for food but could not explain what had happened to the meals or if they had been bought at the beginning of the week or not. Neighbours told us a person asked them for milk or to open cans of food on several occasions.

Although a risk assessment was in place for when the person had sleepless nights, it did not say how the behaviour was to be managed, and was last reviewed in July 2014. There were no behaviour charts in place or any outlined triggers to person's behaviour. This did not ensure that a new member of staff or agency staff would know how to manage these behaviours or how to take consistent action.

We were told by the provider and neighbours and found on our visits that there was not always a member of staff available at the service in order to support the needs of the individual. We looked through records and found that there were days where there were no entries which could signify staff being present. The provider also confirmed that a member of staff had resigned in November when the provider had turned up and found them absent from duty. People in the neighbourhood approached us when we were waiting to gain access to the property and said they had witnessed the person throwing things out of the window including crockery and had broken the fence. We did not witness any similar behaviour during our visits but saw a broken fence and that the person's first floor window was always opened. This was a potential risk as restrictors should have been in place on the window. We were told of an incident when a person was lying in the front garden and had been helped up by the neighbour.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were cared for in an environment that was unsuitable. Although the communal areas were clean, the person's room was very dirty. The door, the bed, and the cabinets were damaged. The person was sleeping on a mattress on the floor. The beige carpet had patches of dirt everywhere. Although the person had damaged the property, nothing had been done to repair this damage which was a potential accident or hazard. The provider said the person would only damage it again. However, this was a risk as the wooden door had exposed wood which could cause an injury and the room could pose an infection control risk as it was visibly dirty.

An out of use medicine cupboard which had a glass door that was shattered had also not been repaired. When asked, the provider said most of the damage had occurred between February and April 2014 and they would not be repairing it until the person moved out.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were possible neglect and acts of omission which could cause harm to people who use the service. We were told by neighbours about safeguarding incidents which we had no record of. One incident was about a person using the service walking in the middle of a busy road at the front of the house.

Another was an episode when an individual was naked in the garden of the service at night and there seemed to be no staff with him. The provider told us staff had said that the person had gone in the garden half naked and was asked to come back in. We saw another episode recorded in the daily log where the person had attempted to boil bleach. Although the notes dated 28 February 2014 said they spoke to the duty community mental health team, we did not see a safeguarding notification or an outcome of

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Is the service safe?

the safeguarding investigation. There was no documented increased monitoring of the person to show further intervention although we were told by the provider and saw as required medicine had been prescribed.

Neighbours said sometimes at night noise continued till after midnight despite there being staff on duty and recalled two incidents where they had called the police because of noise. We contacted the police to verify this as there were no records to confirm this within the service. The provider said the person was nocturnal and did pace up and down and played loud music at night but there was someone with him every night.

The provider did not have suitable arrangements in place to protect people against the risk of unlawful excessive restraint. We found that the person living at the home had no access to the lounge as this was kept locked. We were told by the provider that this was to stop them from damaging the property. We did not see any appropriate risk assessment or deprivation of liberty safeguard for this form of control and restraint which restricted the person from entering the main lounge when they wanted.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered person did not protect people against the risks associated with unsafe use and management of medicines. We saw inappropriate arrangements for the recording and safe keeping of medicines. We found that medicine administration record sheets (MARS) were not completed correctly and did not indicate whether medicine was to be given regularly or when required. Prescriptions were sometimes inaccurate as doses were missing from the MARS sheets although the medicine had been signed for as administered.

Medicines were stored in a filing cabinet that was not very secure as it could easily be forced open.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

The service did not have suitable arrangements in place in order to ensure that staff were appropriately supported, to enable them to deliver care and treatment to service users safely. Staff did not receive appropriate training, professional development, supervision and appraisal. When we inspected on 27 November 2014, we were told two staff besides the manager were employed by the service. We saw no appraisal or supervision records in place. We were told supervision was done verbally and staff meetings were not recorded as there were only two staff besides the manager. There was no documentation to support this. We could not talk to any of the staff because the provider said one person had resigned and the other was on holiday. The provider told us they were covering the six hours of support at night.

Staff did not receive appropriate training to enable them to support people with mental health needs .We found no evidence to suggest that any staff had undertaken Health and Safety training. Skills for care good practice recommend that induction training should cover handling information, dignity, infection control, first aid and fire safety. We did not see any evidence of staff's completed induction process at Samuelson lodge. Within the staff file that was made available to us on 5 December 2014 we saw an induction completed for another care company dated May 2014. However, this would not be transferable as policies and practices differ between services. We were told by the manager that one staff member had resigned following not carrying out their duties. When asked for evidence we were shown a text message conversation but no human resource record to support this.

We did not see any specific training related to mental health in the one staff file that was provided to us on the day of inspection. We found no evidence of staff meetings. This shows that people were at risk because they were not cared for by staff who were suitably trained or supported to deliver good care.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before people received any care or treatment they were asked for their consent and the provider acted according to their wishes. The provider demonstrated how they gained consent before delivering care. The provider described the processes that would be followed if capacity to consent were absent and the steps that would need to be taken to lawfully deprive a person of their liberty.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. We had not received any copies of applications for DoLS and found no evidence to show that applications had been made to the local authority. However, the provider did not always follow the steps to be taken to lawfully deprive a person of their liberty as the person had restricted access within the home as some areas were locked.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were inadequate measures in place to ensure people were supported to choose and eat a balanced diet. There was a support plan in place to assist the person with shopping and cooking which was not followed. We found no meal plans and were told that frozen microwaveable meals were purchased. The person had a supply of cold drinks and hot beverages. However, there was no food in the fridge freezer. When we asked about this and we were told by the provider that the person did not always allow staff to assist them with weekly shopping and would eat at a relative's house. We were not assured that people ate a balanced diet daily. This meant they were at risk of malnutrition.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

The service did not always ensure the dignity, privacy and independence of people who used the service. We were told by two individuals who lived in the neighbourhood that staff had disclosed one person's diagnosis to them, which was in breach of that person's confidentiality.

People were not supported to engage in meaningful activities. The service did not provide opportunities to enable people to take part in activities that may interest them.

On admission in December 2013 an interest's form (an assessment of a person's hobbies and likes) indicated that a person was interested in going to the gym and watching football matches. None of this had happened and we saw no evidence that attempts had been made to support these interests in the records we reviewed. This did not encourage people who used the service to develop their interests or engage with the community.

The person living at the service was left for prolonged periods of time without supervision.

A person was not always supported to make the right choices about their care and treatment. For example a support plan stated that a person needed support to choose and cook meals. However, the provider told us that they encouraged frozen meals. On 27 November there were no frozen meals. Only cold drinks and beverages were available.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us that "staff are alright" and "look after me well." They told us that they were free to go out and come back as they pleased.

On the day of our visit we observed interactions between the staff and a person using the service. It was clear that the placement had broken down as an emphasis was more on the challenging behaviour presented by a person rather than therapeutic support that could be offered. We also saw rules by which people who lived at the service were required to comply with which were very prescriptive about who could visit the service.

Records showed that a person had a support group to support them with addiction problems. However, they had never attended any support group sessions whist living at the service. The above did not encourage or demonstrate a positive supportive environment for people using the service.

Inadequate

Is the service responsive?

Our findings

We saw that at times care was assessed and delivered in response to individual needs. For example we were told and saw in some of the daily record sheets that support had been sought from the community mental health team in order to change a person's medicine when their behaviour became erratic. The person was also able to keep in touch with relatives and went to visit them on a regular basis. The provider and the Community Psychiatric Nurse (CPN) told us that they coordinated weekly to ensure that the CPN came to administer treatment when the person who used the service was available.

The provider said that a recovery model was in place. This model was intended to support people to become more independent and potentially go on to live independently. However, the support plan and risk assessments we saw in place did not always support this. They were not always reviewed in a timely manner. For example assessments had been made when people started to use the service but these were not always updated. Activities and interests noted on admission were not always followed up. We did not see any evidence of these activities being encouraged or supported, these included going to the gym and watching football matches.

The provider told us that the support given was only at night when staff were on duty and not according to the written care plan which stated specified times of care at regular intervals during the day. We saw no evidence of any input relating to life skills such as budgeting and cleaning. .

There was a complaints policy in place which was clear about the reporting and investigative process. We were told that there had been no formal complaints and the person we spoke to said they had no complaints about the service. They said they would speak to the person on duty should they have any complaints.

There was no formal system in place to obtain feedback from people or their relatives in order to improve the service. There was no evidence of involvement of the person using the service in the care plans and risk assessments we reviewed.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The service was not well –led. People were not protected against the risks of unsafe care and treatment arising from a lack of accurate records of care. The support plan we saw in place had not been updated as it showed that care was being given at regular intervals during the day, whereas the provider told us and daily records showed us that care hours were only being provided at night. This was not safe for the person as they were left unsupervised. We found gaps in the daily record sheets on several days between August and November 2014 where care given was not recorded. Although we were told and shown one safety checklist it was not dated. We asked and were told that there were no records made of staff supervision and no staff rota for the two members of staff employed by the service. Therefore records about care, staff and the premises were not accurate and did not reflect the current needs of people.

Records were not kept in a secure place and not easily available. For example staff interview records and application forms were kept in the manager's bag. This was not safe and confidential way to store people's personal records and did not follow records management guidance.

This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was not abiding by its ethos which said "Our Clients dignity, options and choices/preferences come first. Clients/Residents Charter and complaints procedures are in place with regular community meetings held to vent their views." We saw no evidence of regular meetings and were told by the provider that these did not happen. Documented choices and interests of the person living at the service had not been supported. These included activities such as going out to watch football.

The manager did not ensure that there was always a member staff at the service despite being registered as a service that provides 24 hour staffing. The service was run by the manager and two staff who were not present on the days of our visit.

The provider told us that communication was via a communication book as staff did not meet.

There were inadequate systems in place to monitor the quality of care delivered, performance of staff and risk assessments. We asked for the latest quality audits and were shown one undated health and safety checklist. We found no evidence of a structured system in place to obtain and action people's views. There were no staff rotas for us to verify which staff were on duty and what times they worked. We were told that the provider and agency staff were covering the shifts currently. There was no staff supervision or appraisals for the staff employed.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.